

**REPORT AND RECOMMENDATIONS
OF THE
DENTAL HEALTH TASK FORCE
TO THE
MISSOURI RURAL HEALTH COALITION
INITIATIVE**

Presented to

The Missouri Office of Rural Health Advisory Commission

Originally prepared by

The Office of Rural Health

as a report to

Governor Carnahan and the Missouri Legislature

The significant role oral health plays in overall health status is well documented in the scientific literature. Unfortunately, this impact is often overlooked in health policy decisions. Too often, we see health policy overlooked in health policy decisions made on the basis of medical, dental, and other components, rather than an integrated health component. This tends to fragment care which increases costs and is detrimental to the health of many Missourians.

Lack of access to adequate preventive and restorative oral health care leads to a crisis management situation. Citizens with pain, infection, and swelling show up at hospital emergency rooms. They are treated with antibiotics and pain medication which addresses the immediate symptoms, but does not alleviate the cause. This is often uncompensated care for the hospital to absorb. When the next acute episode occurs, the cycle is repeated.

This lack of access to adequate preventive and restorative care in rural Missouri often revolves around the lack of adequate Medicaid providers. In some counties there are no dental Medicaid providers at all. This situation has developed over time to the point where the current dental Medicaid budget is barely 1% of the total Medicaid budget. The current fee structure is about 23-25% of the usual and customary fee. The average general dentistry practice in Missouri runs about a 60% overhead cost. This means that when a dentist treated a Medicaid patient, he/she is reimbursed less than half of the cost to treat. Obviously, no one can continue indefinitely to do business that way. There had not been a Medicaid fee adjustment for general dentistry since the mid-1970's. Few things in our society are still the same price that they were in the '70's.

Adequate funding, in and of itself, would not necessarily result in complete amelioration of this situation, although it would be a significant first step. Concerns about poor provider relations from the Department of Social Services, and patient apathy, complicate an already difficult situation. However, there is reason to believe that the dental profession would respond, if the funding issue were seriously addressed.

There was some hope that this issue would be addressed, at least for the most needy children, in the OBRA '89 legislation. This federal budget mandated expansion of the Early Periodic Screening Diagnosis and Treatment Program (now called Healthy Children and Youth) and contained participation requirement. Unfortunately, once again, the medical and dental components were separated and the imperatives were not applied to the dental component.

In summation, there are many dentists in rural communities who treat needy and uninsured patients and simply absorb the cost rather than deal with the complicated and underfunded government programs. While this is commendable on the part of the dental profession, it does not adequately nor equitably address the oral health care and health care needs of many rural Missourians. One segment of our society should not have to bear the burden for what is accepted as a societal responsibility. One segment of our society should not have to suffer ill health because society as a whole will not accept its responsibilities.

Prevention of disease and suffering is always less costly than treating the damage of the disease. This axiom is perhaps, best illustrated in oral health. When children grow up with an adequately fluoridated water supply, and dental sealants are applied in a timely fashion to at risk teeth, and the children develop good oral hygiene practices, fostered by a strong oral health component in the school curriculum, they can grow to adulthood with an intact dentition, i.e., no fillings and no decay.

Recommendations

1. Statewide mandatory optimal fluoridation of all community water supplies.
2. Fluoride supplements for children below 185% of poverty in those areas not served by a community water supply.
3. Mandatory dental exam and follow-up for all children entering the school system for the first time.
4. Adequate funding for the dental portion of the Medicaid program.
5. Dental sealants for first and second permanent molars for children below 185% of poverty.
6. Insure that there is a strong health component including oral health in the elementary school curriculum.

These recommendations would be relatively inexpensive to implement and would be more than offset by better oral health and healthier citizens less dependent on Medicaid acute care.

